

Florida Medicaid: Program Overview

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The Federal Medicaid Program

- In 1965, the federal Social Security Act was amended to establish two major national health care programs: Title XVIII (Medicare) and Title XIX (Medicaid).
- The Medicaid program is a state administered program funded by both the Federal Government and the individual state governments.

The Federal Medicaid Program

- Federal Medicaid laws and regulations mandate certain benefits for certain populations and states must administer their programs under federally approved state plans.
- To participate, states are required to cover certain mandatory populations and services, while federal matching funds are available if a state chooses to cover other optional populations and services.

The Federal Medicaid Program

- States must submit a Medicaid State Plan to the federal Centers for Medicare and Medicaid Services (CMS) and administer their programs under federally approved state plans.
- The Plan outlines current Medicaid eligibility standards, policies and reimbursement methodologies to ensure the State program receives matching federal funds under title XIX of the Social Security Act.
- Services must be available statewide in the same amount, duration and scope.

Medicaid Waivers

- In order for states to implement programs which deviate from their state plan (to vary by geographic areas, amount, duration and scope), the state must request a waiver.
- A waiver is a program requested by a state and approved by the Centers for Medicare and Medicaid Services (CMS) that waives certain provisions of the Social Security Act.
- Waiver types:
 - 1915(b)
 - 1915(c)
 - 1115

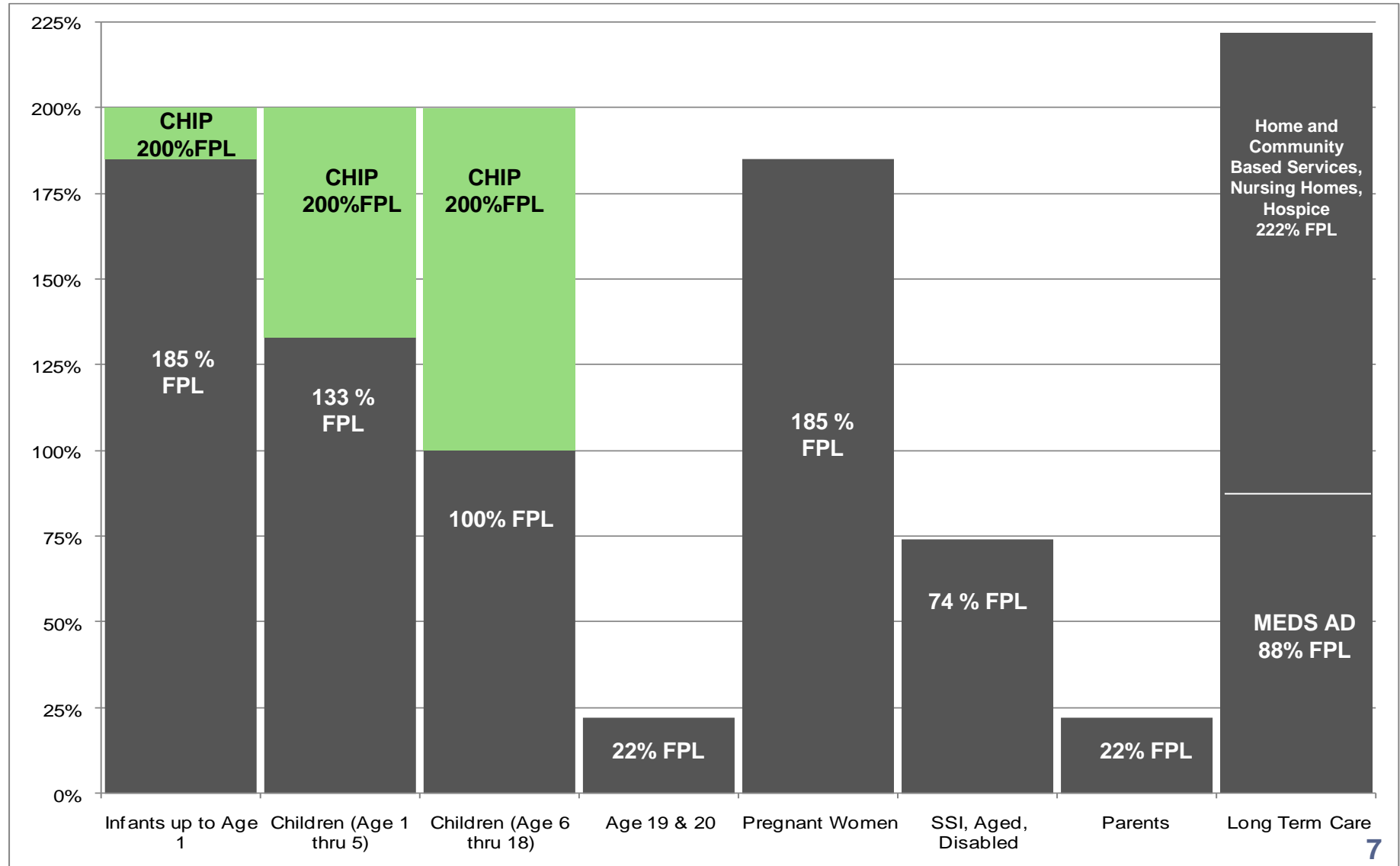
The Florida Medicaid Program

- Florida is the fifth largest state in terms of Medicaid expenditures, with estimated spending of over \$20.3 billion for fiscal year 2010-2011 (July 2010 through June 2011).
- More than 2.9 million Floridians are eligible for Medicaid coverage. They are elders, disabled people, families, pregnant women, and children in low-income families. Florida has the fourth largest Medicaid population in the country.

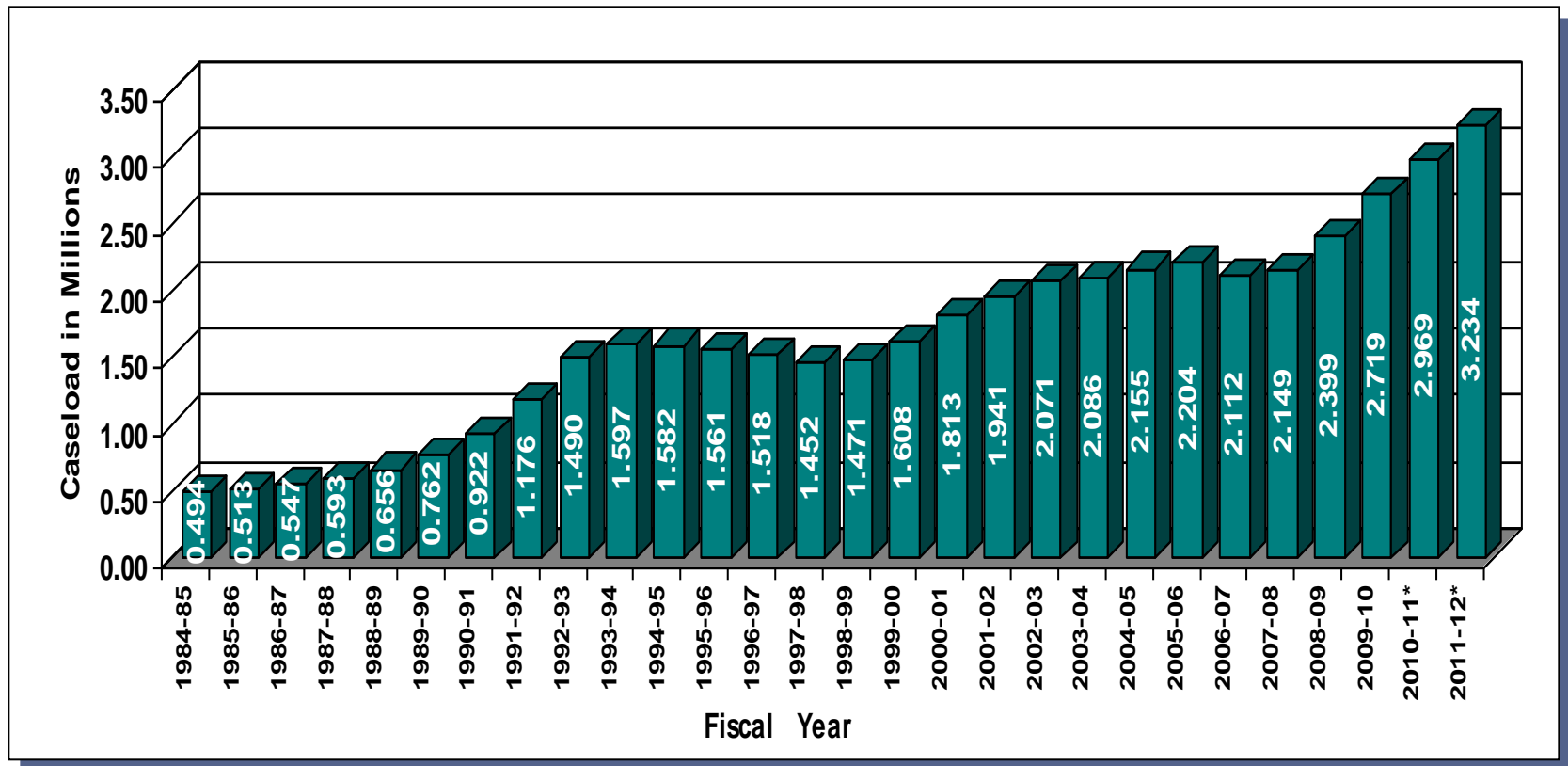
Demographics

- Florida is unique in that our Medicaid program serves a large number of seniors and has a significant population of disabled beneficiaries.
- Florida Medicaid does not cover all low income individuals, but does cover
 - 27% of children.
 - 51.2% of deliveries.
 - 63% of nursing home days.
 - 1,162,020 adults - parents, aged and disabled.
- Different populations have different impacts on program expenditures.
- In general, services provided to the elderly and the disabled costs more per person/ per month that services provided to children or healthy adults.

Medicaid / CHIP Eligibility Levels



Growth in Medicaid Average Monthly Caseload



Source: Medicaid Services Eligibility Subsystem Reports.

*FY 2010-11 November 2010 Caseload Social Services Estimating Conference.

*FY 2011-12 November 2010 Caseload Social Services Estimating Conference.

Enrollment Growth in Florida Medicaid

- Enrollment growth has been the primary driver of increased program costs.
- While historically there have been program changes or expansions that resulted in enrollment growth, recent growth is specifically related to changes in population demographics and economic pressures.
- According to the National Bureau of Economic Research, the current recession began in December of 2007. During SFY 2007-2008, average monthly program enrollment was 2.149 million. For SFY **2011-2012** , enrollment is expected to reach 3.234 million. This would be an increase of 50%.

Federal Maintenance of Effort

- If a state chooses to participate in the Medicaid program, the state is then obligated to provide services to all individuals who are eligible for the program.
 - While historically states have had the ability to determine what optional eligibility levels to maintain (outside of the federally required minimum eligibility levels), they cannot “cap” the number of enrollees once program parameters are set.
 - Maintenance of Effort provisions under the ARRA and ACA limit states’ abilities to reduce program eligibility.

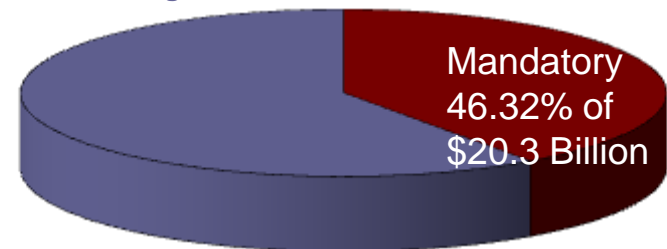
Federal Maintenance of Effort

- The Affordable Care Act of 2010 requires states to maintain certain eligibility criteria which may effectively preclude the reduction of eligibility. Under the maintenance of effort requirement in the Affordable Care Act,
 - States must maintain their current Medicaid eligibility levels for adults through December 31, 2013.
 - States are prohibited from reducing eligibility levels for children through September 30, 2019.
 - Secretary (HHS) can waive the requirement for nonpregnant, nondisabled adults with income above 133% if the State certifies that the State has a budget deficit, or is projected to have a budget deficit.
 - Penalty for violation of maintenance of effort provision is loss of all federal financial participation in the state program.

Florida Medicaid Mandatory Services

- Advanced Registered Nurse Practitioner Services
- Early & Periodic Screening, Diagnosis and Treatment of Children (EPSDT)/Child Health Check-Up
- Family Planning
- Home Health Care
- Hospital Inpatient
- Hospital Outpatient
- Independent Lab
- Nursing Facility
- Personal Care Services
- Physician Services
- Portable X-ray Services
- Private Duty Nursing
- Respiratory, Speech, Occupational Therapy
- Rural Health
- Therapeutic Services for Children
- Transportation

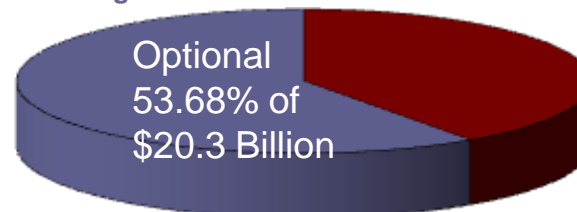
Florida Medicaid Mandatory Services for
All Eligibles FY 2010-11



Florida Medicaid Optional Services*

- Adult Dental Services
- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care Services
- Birth Center Services
- Hearing Services
- Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Healthy Start Services
- Home and Community-Based Services
- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Home Care
- Optometric Services
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Management (MediPass)
- Registered Nurse First Assistant Services
- School-Based Services
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management)

Florida Medicaid Optional Services for
All Eligibles FY 2010-11



*States are required to provide any medically necessary care required by child eligibles.

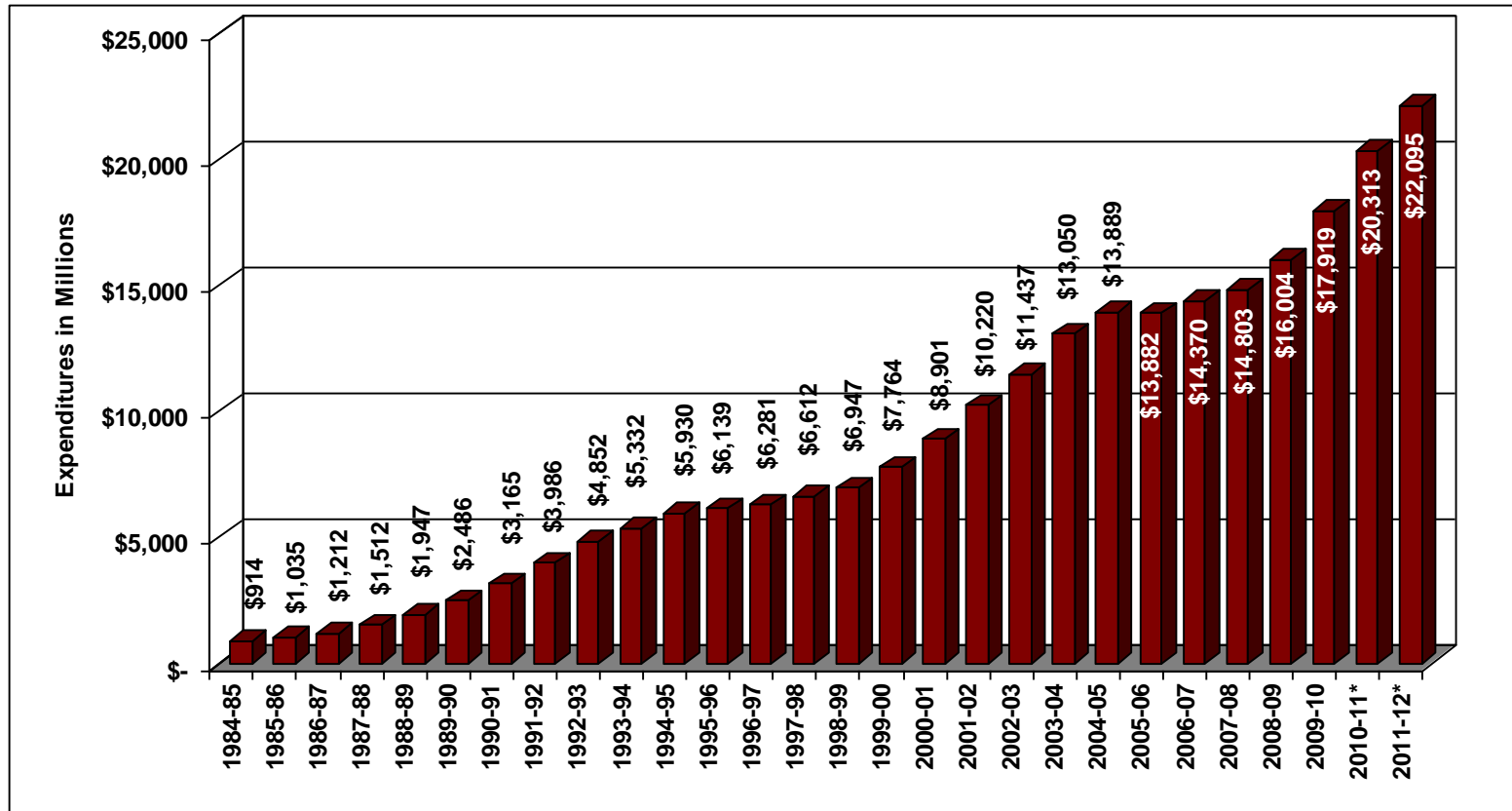
Federal Requirements

- A state must provide medically necessary state plan services to enrollees.
- A state must cover all mandatory services
- A state determines coverage of optional services.
 - While states can maintain a measure of control over per recipient costs through program efficiencies, elimination of inappropriate utilization and most recently for Florida, reductions in the rates paid to Medicaid institutional providers.

Growth of Medicaid Expenditures

- As previously stated, enrollment growth is the primary driver of program expenses.
- Total expenditures for the Florida Medicaid Program for FY 2007-08 were \$14.8 billion with a per member/per month (PMPM) cost of \$574.10.
- It is estimated that actual program costs for FY 2010-11 will be approximately \$20.3 billion, with a PMPM costs of \$570.19.
- Enrollment in the Florida Medicaid program increased by 38%, while total program expenditures are anticipated to have increased by 37% by the end of FY **2010-2011**. During this same period, per member per month costs have been reduced by .7%.

Growth In Medicaid Service Expenditures

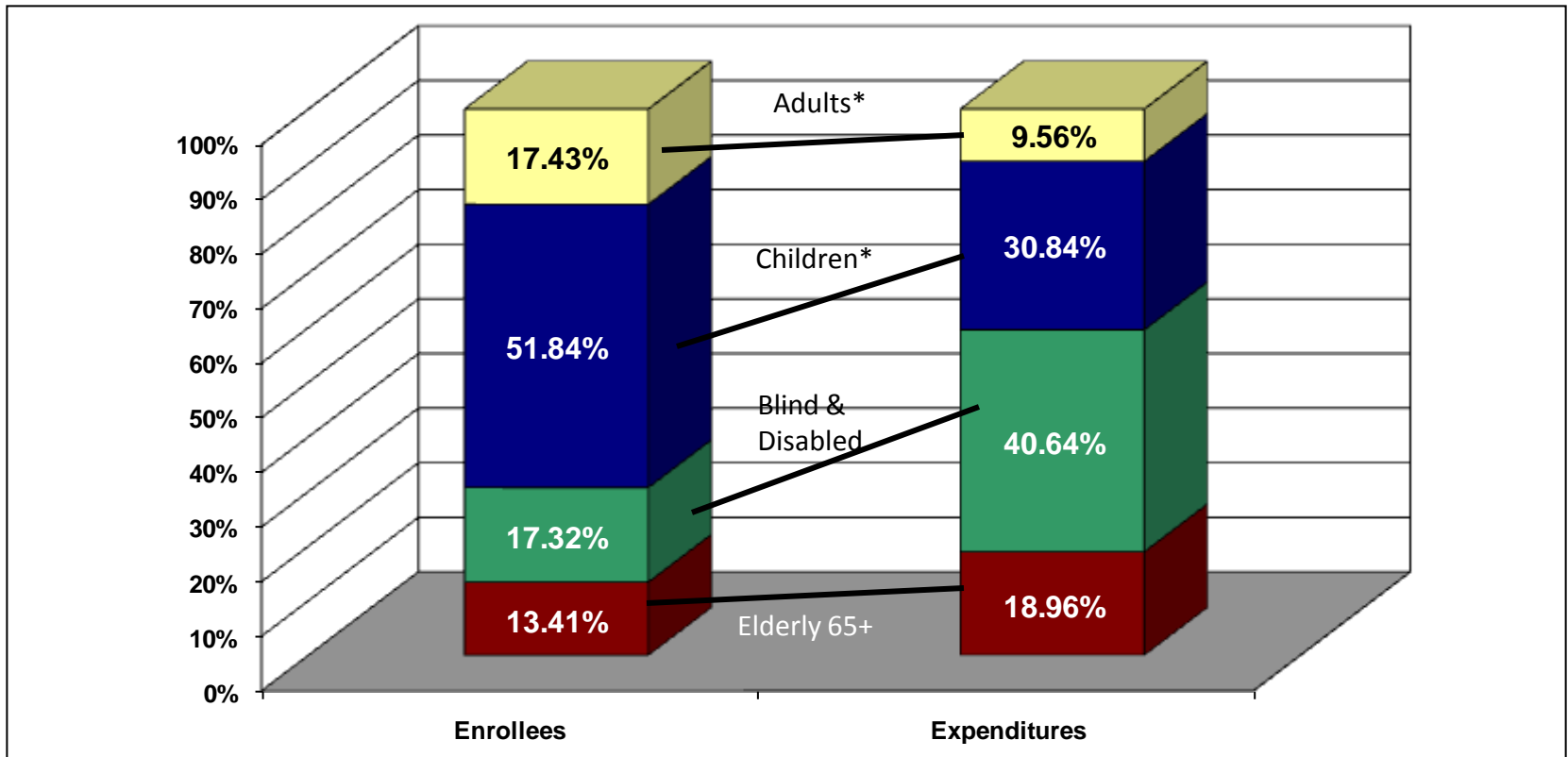


Source: Medicaid Services' Budget Forecasting System Reports.

*FY 2010-11 December 2010 Social Services Estimating Conference.

*FY 2011-12 December 2010 Social Services Estimating Conference.

Medicaid Budget - How it is Spent FY 2009-10



•Adults and children refers to non disabled adults and children.

TANF and SSI Related Eligibility Groups for 2010-11

	Total Budget	Avg Monthly Caseload	PMPM
Supplemental Security Income (SSI)	\$10,648,441,850	598,960	\$1,482
Temporary Assistance for Needy Families (TANF)	\$2,906,619,770	911,691	\$266
Medically Needy	\$1,159,937,299	45,091	\$2,144
Children < = 100% of Poverty	\$1,124,673,729	668,403	\$140
Children > 100% of Poverty	\$141,936,520	70,165	\$169
Children – Medicaid Expansion Under Title XXI	\$3,376,035	780	\$361
Pregnant Women < = 100% of Poverty	\$732,794,709	69,514	\$878
Pregnant Women > 100% of Poverty	\$154,239,355	15,954	\$806
Family Planning Waiver	\$479,469	2,272	\$18
Categorically Eligible	\$588,031,695	249,127	\$197
Elderly and Disabled (MEDS AD)	\$794,839,040	38,046	\$1,741
Qualified Medicare Beneficiaries (QMB/SLMB/QI)	\$524,966,464	290,236	\$151
Refugee General Assistance	\$32,758,850	8,484	\$322
Other	\$1,499,603,024	N/A	N/A
Total	\$20,312,697,809	2,968,723	\$570

Title XIX Federal Medical Assistance Percentage (FMAP): Impact of FMAP

- As program enrollment has increased, program expenditures have likewise increased.
- However, general revenue expenditures do not necessarily directly correlate to changes to total program expenditures for several reasons:
 - Changes to federal financial participation (FMAP)
 - Increase in local government or facility participation in program costs (Intergovernmental Transfers or facility assessments)

Title XIX Federal Medical Assistance Percentage (FMAP)

Federal Fiscal Year	Federal Share	State Share	Total
2007 (10/1/06 – 9/30/07)	58.76%	41.24%	100%
2008 (10/1/07 – 9/30/08)	56.83%	43.17%	100%
2009 (10/1/08 – 9/30/09)	55.40%	44.60%	100%
2010 (10/1/09 – 9/30/10)	67.64%	32.36%	100%
2011 (10/1/10 – 9/30/11) Q1	67.64%	32.36%	100%
2011 (10/1/10 – 9/30/11) Q2	64.81%	35.19%	100%
2011 (10/1/10 – 9/30/11) Q2	62.93%	37.07%	100%
2011 (10/1/10 – 9/30/11) Q4	55.45%	44.55%	100%
2012 (10/1/11 – 9/30/12)	56.04%	43.96%	100%

During FFY 2011, the phase down of Enhanced ARRA FMAP occurs. The resulting blended FMAP rate for State Fiscal Year 2010-2011 is 64.82%.

Enhanced FMAP

- The American Recovery and Reinvestment Act of 2009 (the Stimulus) provided for an across-the-board increase in federal participation (FMAP) funding percentage given to states.
- The amount of the increase was based on a variable including the unemployment for each state, with the highest tier receiving an 11.5% increase.
- Florida's unemployment qualified the state for the highest tier. The enhanced FMAP was authorized through December 31, 2010 and a stepped down version of the enhanced FMAP will be in place from January 1, 2011 through June 30, 2011.

Federal Medical Assistance Percentage (FMAP)

- The FMAP formula is based upon the ratio of the state per capita income to the national per capita income and is promulgated by the Department of Health and Human Services between October 1 and November 30 of each year. The formula used to determine each state's FMAP uses the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce, Bureau of Economic Analysis.

Federal Medical Assistance Percentage (FMAP)

- The FMAP is a lagging economic indicator designed to capture normal fluctuations in the economic health of the state. As a state's economy fluctuates (improves or declines) relative to the national average, the amount of federal funding provided is adjusted (decreased or increased).

Impact of Loss of FMAP Enhancement

- Once the ARRA Enhanced FMAP ends, Florida's FMAP will be 55.84% for SFY 2011-2012,
- Based on the December 2010 Social Services Estimating Conference for Medicaid Expenditures, it is anticipated that the Medicaid program will have a need for additional general revenue in the amount of \$2,095,688,800 for SFY 2011-2012.
 - Of the total GR need of \$2,095,688,800 for SFY 2011-2012 \$1,358,658,617 is needed due to the change in FMAP.

The Florida Medicaid Program

- To meet the needs of Medicaid participants, Florida Medicaid has approximately 100,000 Florida Medicaid enrolled individual providers and facilities offering health care services as well as 24 Medicaid Managed Care plans (18 HMOs and 6 PSNs).
- Medicaid's contracted Fiscal Agent processes approximately 135 million claim lines every year.

Managed Care in Florida Medicaid Medicaid Enrollment Today

(January 1, 2011)

Delivery System	Number of Plans	Number of Counties	Non-Reform County Enrollment as of January 1, 2011	Reform County Enrollment as of January 1, 2011	Statewide Enrollment
Health Maintenance Organization (Non-Reform)	17	33	957,639	931	958,570
Health Maintenance Organization (Reform)	8	5	0	148,901	148,901
FFS Provider Service Network	4	6	8,458	123,594	132,052
Capitated Provider Service Network	2	10	60,934	0	60,934
Nursing Home Diversion	17	39	15,100	2,569	17,669
Fee-For-Service	N/A	67	785,447	128,994	914,441
MediPass	N/A	67	603,629	5,328	608,957

Fee-for-Service

- The fee-for-service system serves those Medicaid recipients who are not eligible for or enrolled in MediPass, Managed Care or Disease Management.
 - The recipients include new eligibles, those in the Medically Needy program, the Family Planning Waiver, or residing in institutions.
- Fee-for-service recipients may receive services from any enrolled Medicaid provider, with limited coordination of care.
- Within the fee-for-service system, enrolled Medicaid providers have the option to choose whether they accept a certain number of clients or whether they accept new Medicaid clients.
- Providers do not bear any financial risk for their patients.
- There are more than 107,000 enrolled and 71,000 active providers (providers who have had a paid claim within the past 12 months).

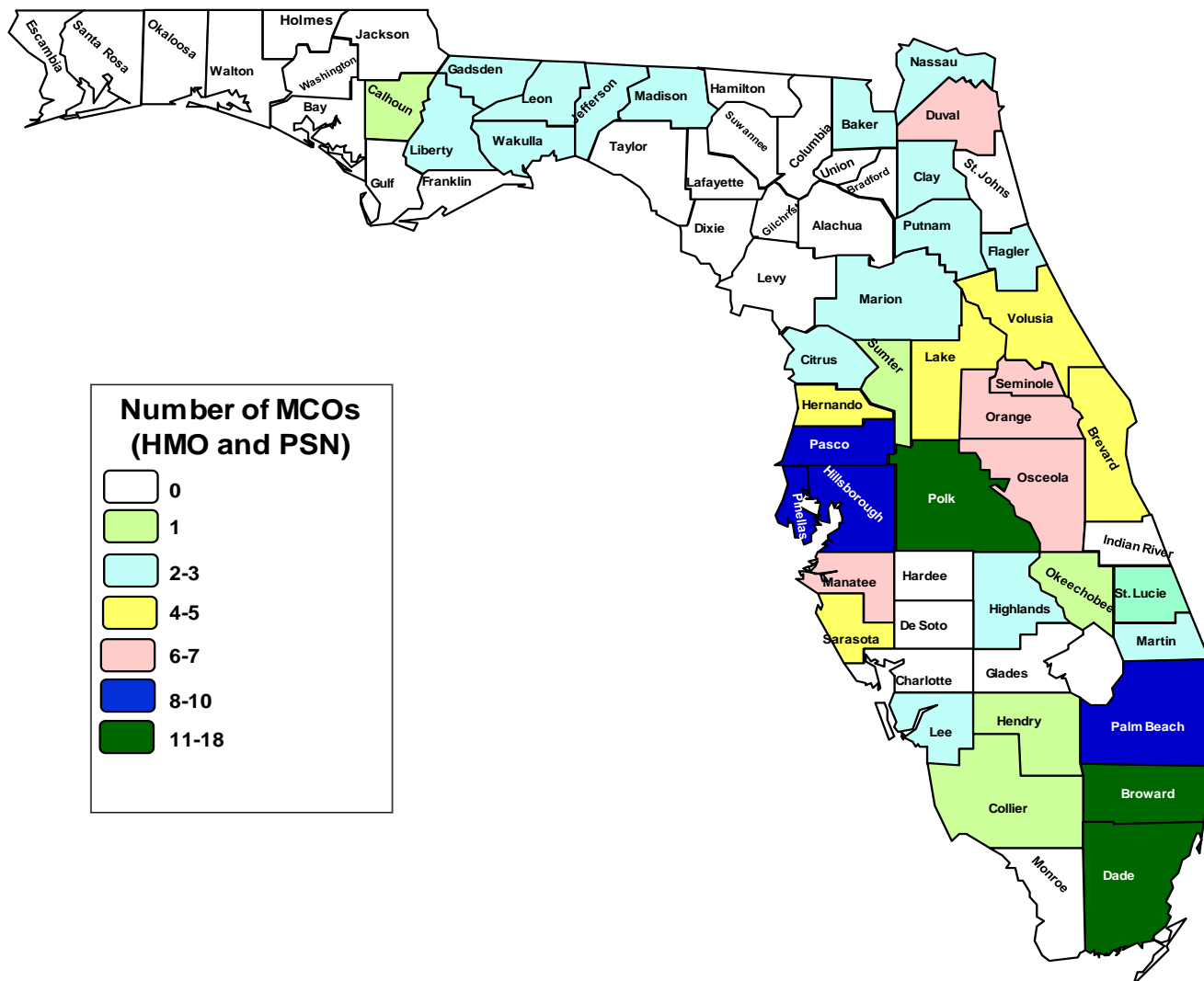
- MediPass is the Florida Medicaid primary care case management program.
- Services to MediPass members are reimbursed on a fee-for-service basis.
- MediPass primary care providers are paid a \$2.00 per member per month case management fee.
- Primary care providers (PCPs) are responsible for providing primary care and authorizing the specialty care provided to their MediPass enrollees.
- Services such as vision, hearing, dental, mental health and family planning services are not managed by the MediPass PCP.
- MediPass providers do not bear risk for their patients but do have requirements in place for case management, care coordination, and preventative care.
- There are approximately 2,500 enrolled MediPass provider practices with 5,000 total individual providers.

Medicaid Provider Service Networks

- Provider Service Networks (PSN) are defined in s. 409.912 (4)(d), as an integrated health care delivery system owned and operated by a health care provider, or group of affiliated health care providers which provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers.
- PSNs are reimbursed on a fee-for-service or capitated basis.
- PSNs are required by contract to ensure that their enrollees have access to all Medicaid state plan services and a complete network of providers.
- The PSN does bear risk for enrolled recipients.
- Capitated PSNs must meet qualifications similar to HMOs.
- There are currently 6 PSNs participating in Florida Medicaid (reform and non-reform).

Health Maintenance Organizations

- A Health Maintenance Organization (HMO) is an entity licensed under Chapter 641, Florida Statutes.
- HMOs provide comprehensive Medicaid services to a defined population of Medicaid recipients.
- The Agency contracts with HMOs on a prepaid fixed monthly rate per member (i.e. capitation rate) for which the HMO assumes all risk for providing covered services to their enrollees.
- HMOs are required by contract to ensure that their enrollees have access to all Medicaid state plan services and a complete network of providers. HMO networks are not limited to Medicaid participating providers.
- Some plans have expanded their benefits beyond those normally required; example: preventive adult dental.
- There are currently 18 HMOs participating in Florida Medicaid (reform and non-reform).



Services Provided

- Capitated health plans are required to provide their enrollees with all Medicaid state plan services, with certain exceptions.
- Some services have been “carved out” from the rates paid to capitated plans and are provided to plan enrollees through other service delivery systems outside of the plan network. Examples include:
 - Long term care
 - Nursing Home
 - Home and Community Based Waivers

Benefits of Managed Care

- Contract requirements ensure accountability
- Improve access to health care services.
- Recipient choice.
- Flexibility to offer services not otherwise covered
- Slow the rate of growth of expenditures:
 - Improved care coordination
 - Reduction of over-utilization
 - Effective method of fighting fraud

Issues to Consider: Fraud and Abuse

- It should be noted that Medicaid fraud and abuse is primarily a fee-for-service system problem. Reducing the fee-for-services marketplace through increased penetration of managed care into the marketplace, will result in cost avoidance and expenditure predictability through additional fraud and abuse prevention.
- Managed care can be a tool for Medicaid programs to more effectively use resources while improving outcomes. As the Agency and the state continue to look for new ways to control the Medicaid budget and ensure that fraud and abuse is minimized, the Agency has implemented a series of program improvements relating to increasing managed care plan quality and accountability.

Issues to Consider: Fraud and Abuse

- Plans have a financial incentive to be vigilant about preventing, identifying, and combating their own provider fraud and abuse.
- The Agency has enhanced fraud and abuse requirements in the contract.
- Detection of fraud, abuse and over payments, will require additional mechanisms and expertise to evaluate program risks.

Other Issues to Consider: Managed Care

- Open application
 - Capitated MCO & PSN, FFS PSN
 - Any qualified plan may provide services
- Procurement
 - Prepaid Behavioral Health
 - Ability to challenge procurement

Other Issues to Consider: Managed Care

- Hospital Rate Negotiation with Managed Care plans
- Impact on “carve outs” (Behavioral Health, Dental, Transportation)
- Impact on Intergovernmental Transfers (exempt rate, buy-backs, DSH)
- Low Income Pool funding

Questions?